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ABSTRACT

Presented is a detailed case study of an 8-year-old socially withdrawn girl with elective mutism. Reviewed are early developmental data, and described are the therapeutic processes involved in her treatment in a psychiatric facility, including speech therapy and individual play sessions. Theoretical considerations on the origin of her mutism are discussed. The theory is set forth that she elected not to talk as a protective device against oral aggression in addition to a means of rebellion and a controlling device against her parents. (CL)

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SUCCESSFUL TREATMENT OF AN "ELECTIVE MUTISM" CASE WITH BEHAVIOR MODIFICATION TECHNIQUES AND A MULTI-DISCIPLINARY APPROACH

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To the ERIC clearinghouse on Handicapped and gifted children

Respectfully,

Ismail Ersevim, M.D.

8.15.78

SUCCESSFUL TREATMENT OF AN "ELECTIVE MUTISM" CASE

WITH BEHAVIOR MODIFICATION TECHNIQUES AND A MULTI_DISCIPLINARY APPROACH (*)

Ismail Ersevim, M.D., - Deborah Pavelle, M.A., CCC - Fredda Zuckermann ACSW (**)

Kim is a very cute, blonde, eight-year old girl who was hospitalized at the Pediatric-Psychiatric Unit of the New England Memorial Hospital in Stoneham, Mass. on July 6, 1976. She was accompanied to the hospital by her mother and older sister.

Mrs. C., Kim's mother, had applied to the outpatient department of the hospital in May, 1976. The patient had at that time been in treatment for seven months at a local community guidance center, having been referred there by her school counselor. The referral was initiated because of the child's mutism and socially withdrawn behavior, and her refusal to verbally participate in class or to interact with her schoolmates. She also had occasional temper tantrums and bedwetting episodes. Kim attended the 2nd grade in the public school at the time of admission, and in spite of the fact that she had not spoken a single word in school, she had been doing her written work.

As Kim's therapist was leaving the guidance center and no immediate replacement could be provided, application for treatment at our hospital ensued. At the time of termination from the local clinic in early May, little improvement in Kim's behavior was noted. Mrs. C. had refused to take an active role in the treatment, and her daughter's subsequent failure to give up her symptoms was seen at least in part as a function of the secondary gains they produced. However, at the time of termination the mother's attitude had changed to the point where

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she was finally manifesting genuine interest in becoming involved in the treatment program.

The patient's father had also been known to this community clinic. He had been in treatment with several therapists in the past. His complaints were extreme shyness, tension and nervousness, and he had been diagnosed as passive-aggressive characterologic difficulty with extreme unconscious hostility toward his wife and mother (who were in conflict with each other for control over Mr. C.) Anxiety symptoms had dated to the time of his marriage in 1965; at the time of contact he was taking Triavil 4-25mg. daily and was employed as a postal clerk, who preferred to work in the evening shift "when everyone is gone and everything is quiet."

Kim is the second oldest of four living children. She has a sister one year older, a sister one year younger, and a brother three years younger. Three miscarriages were scattered throughout, one of them being prior to Kim's birth.

(*) This paper had been presented at the Twenty-Ninth Annual Meeting of the American Association of Psychiatric Services for Children, in Washington, D.C., November 16-20'1977.

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Early Developmental Data

Kim was born in Massachusetts. Mother described the pregnancy with Kim as good and uneventful. The birth was a natural one. She was a breast-fed child until six months of age, and had always had a good appetite. Mother described her in her babyhood as "a cute girl, but never cuddly." In her early months, she had numerous ear infections.

Kim had rolled over at five months and smiled a few weeks after birth. She sat alone at five months and crawled at seven and a half months. She said "mama"and "dada" by the eighth month, and walked by thirteen months.

Mother described Kim in her toddler years as being "somewhat afraid of people" "a self-centered and self-satisfied child". She had stopped talking to strangers alone, and to her family when the strangers were around, right after starting to make sentences by about the 19th-20th month. That had remained until admission.

PEDIATRIC EVALUATION of Kim was normal. All routine laboratory evaluations were found within normal limits. By this token, an Echoancephalogram report (7/7/66) read: "single polaroid print shows no significant shifting of midline structure". Brain Scan (7/9/76) was also negative. First E.E.G. that was taken on 7/8/76 read: "abnormal record because of left sided slow wave activity in the Theta range (5-6/ sec. wave activity in temporal region)"

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The repeated E.E.G. on 7/30/76 read: "Borderline Abnormal, because of some scattered left temporal Theta activity only during the early waking period. The record is not as definitely abnormal as the previous trace of July 8, 1976" We did not pursue a Neurological Consultation.

Before entering into our diagnostic and therapeutic procedures, I would like to describe briefly our Pediatric-Psychiatric Unit at the New England Memorial Hospital, Stoneham, Massachusetts.

I had the privilege of being adviser and co-founder of the Unit in 1974 along with the real founder, the late Dr. Herbert Siegert, a great humanitarian and very able child psychiatrist. The hospital is a modern community general hospital containing a 29-bed Adult and Adolescent Psychiatric Unit that had been established in 1973.

We developed the eight-bed unit in the General Pediatrics Unit, separating it with an unlocked, swinging door. We developed slowly and painfully into a well-rounded multi-disciplined unit, composed of child psychiatrists, social workers, pediatricians, nurses, child care workers, psychologists, occupational therapists, speech therapists, volunteers and students from different disciplines, including Child Psychiatry Fellows affiliated with Harvard University.

We utilize the "Team Concept" with screening and multiple diagnostic procedures, mainly practicing Behavior Modification Techniques, enriched with

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psychoanalytic interpretations and their therapeutic implications.

Every child is assigned to a counselor, regardless of his or her professional treatment backround. The day is programmed for every half-hour for therapeutic diversities, such as small groups, individual times, O.T., field trips, Gym., free-rest hour, combined with activity sessions, family on Sunday evenings, and familytherapy sessions.
Every afternoon, "Community Meetings" are held that include the entire therapeutic community. At the beginning of the week, each child, with the help of an individual counselor, prepares an outline of "goals" , primarily addressing his or her psychopathology. On other afternoons, children are asked directly to report about their days and activities, primarily addressing their behavioral patterns and commitments to their goals; then "requests" are made that may include going on the grounds with the counselor, going to the candy machine and the like. These may be granted or declined by general vote. The last day's request is usually that of becoming "counselor of the day". When the majority vote says "yes", a general hand clapping ensues.
Thus we primarily emphasize promoting the positive attitude and correcting undesirable behavior patterns through confrontation.

Punishment procedures include having the child sit on his chair for a few minutes, sending him to his room, and finally sending him to the "Blue Room" - a very pleasant, well-lit single room with only one mattress on the floor - should a warning and/or an on the spot interpretation of the unacceptable

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behavior prove unsuccessful in controlling the child's noted acting-out. We also use medication such as Ritalin, Mellaril, Thorazine, sodium amytal, tofranil and the like, as an adjunct to milieu therapy, if and when indicated.

Diagnostic and Therapeutic Process

From the very first minute, the entire Staff was aware of what major difficulties we were going to face. Needless to say, the primary concern was how Kim was going to fit in within a therapeutic milieu that depends almost entirely on verbal communication, confrontation, reporting of daily activities and the like which comprise behavioral modification techniques.
For instance, children are not allowed to leave the dining-room table without saying "may I be excused". It was almost impossible not to sympathize with that beautiful creature, who could listen, laugh, and play with a perfectly functioning perceptual system, and all the sensory-motor responses but speech.
By the same token, regardless of how dynamically oriented we are, the clinical diagnosis, if we were able to establish it accurately, was going to play a very important role in treating the child. A diagnosis of autism versus hysteria could have made quite a difference in the application of reward and punishment procedures. As our anxiety rose, the child undoubtedly took her share from it. A number of 'in between' policies and procedures were improvised, modifications of routine from ongoing rules and regulations took place, yet still Kim did not speak. The danger of course was that her pathology would be comfortably accepted by the environment, a condition simulating the previous life style outside.

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Then, we began to enlarge our scope through more consultation with other child psychiatrists, as well as searching the literature for electively mutic children. Unfortunately, the literature addresses the question of "how children develop speech" according to different schools of thought and different speech pathology, with little reference to this very interesting albeit rare phenomenon. Needless to say, the most respectable article was that of Brown and et al's, titled "Diagnosis and Treatment of Elective Mutism in Children" in the Journal of the American Academy of Child Psychiatry (see references) in which ten cases were studied very ingeniously.

Browne et al, had concluded that elective mutism was the family's psychopathology and should be treated accordingly. Children, in general, had close ties with their mothers, and mothers were angry at their husbands. The missing part was that an individual trauma, like an accident or illness during the speech development period was responsible as the precipitating factor. Psychodynamically, elective mutism was considered as a regression to and at the anal-fixation level.

Kim, being an extremely stubborn girl, would sit on the dining room chair for hours, developing blisters and extremely red buttocks, and even falling asleep in that uncomfortable position. We certainly agree that anal defenses might have been set forth, whether in an effort to control the environment through passive hostility, or in trying to control her own annihilation fears and/or fantasies through muteness. However we soon discovered that Kim had some unresolved oral-aggressive issues that may have been quite threatening to her

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and that the release of them, in the form of speech, may have been ego-alien and incompatible with psychological survival while in the presence of mother and father. Through cathecting and/or borrowing their egos, she might have been becoming instantaneously ego-syntonic.
After hypothesizing that possibility, I began to work with her very directly on the issue, asking "Kim, do you think, when you would speak to people, that they are going to swallow you, or something like that?" I did not find an answer one way or another, other than a fixed, fearful, motionless face. I put the question another way, "Kim do you feel that if you talk to me I shall swallow you?" She revealed a graceful smile, a relaxed face and a negative head shake.

One of the ways that I dealt with this core issue was "eating ants together" We pretended to eat ants who by chance were crawling all over the dining-room table, laughing together to tears. In spite of being a subject of public ridicule by other children, it was accepted as a funny game. She was particularly excited when the ants were coming alive, appearing here and there.

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After some weeks of frustration and continuous staff conferences on how to handle the case, we decided to have an attack dose of available therapeutic diversions of different disciplines, such as:

1. Speech evaluation and speech therapy
2. Utilizing more 'positive re-inforcement' techniques, other than corrective attitudes in general.
3. Treating her "as normal" in all activities, e.g. O.T., etc.
4. Instructing the other resident children "not to help Kim by talking for her , asking for her, etc., but bringing them to a closer understanding of her problem.
5. Thorazine, 25mgr, tablets, three times a day.
6. Family Therapy sessions, including Kim, myself, and her individual therapist, Fredda Zuckermann

I do not know which one of them had been a single factor in the ultimate achievement of Kim's being able to speak to people, but I give the first credit to the speech evaluation and speech therapy.

The following notes are taken from our very apt and skilled speech therapist Anne Deborah Pavelle:

> Kim was referred for speech therapy as she was electively mute. She spoke to her parents and siblings. She spoke once to a neighbor and never spoke again when her mother stated she did not speak to people outside the home. The child was electively mute in all social and

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educational situations outside her home. Kim attended speech therapy from August 16, 1976 until her discharge October 13, 1976. She was 8.10 years old. All speech sessions were tape recorded. Prior to the initiation of speech therapy Kim's writing was reviewed by the speech pathologist. Kim appeared to write well using good syntax, and word choice for her age level. It was felt if she could write she undoubtedly spoke in acceptable grammatical units. Her parents stated her articulation was good. She comprehended all language and responded appropriately except for not eliciting speech.

In the first session Kim giggled a lot, and produced and "ih" sound like parts of the giggle for a pig's grunt. She laughed at the therapist making animal sounds. Here is a brief section of the tape of that early lesson. Attempts to get imitation on demand failed. The child was enticed at the prospect of doing things. But she refused to make the sounds letters make, although she copied the alphabet easily and wrote yes/no to questions asked of her. Kim was given the tape recorder and asked to speak into it with the therapist out of the room. This was unsuccessful. In this second session, Kim produced no vocalizations although she wanted to play with the materials provided. It was dicided to try to make play contingent on speech, however minimal. Kim refused to speak. She did not maintain eye contact, and sat rigidly in her chair; she was reluctant to leave the room. She never smiled and barely responded to tickling. She was very unhappy. It was decided not to press the child to have her speak. It was assumed

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pressures greater than this speech therapist's had been placed upon this child. The following session was very relaxed and on August 23 we played with Snow White punch outs. Kim did much creative dramatic play, and laughed for the character "Happy" sneezed for "Sneezy" and grunted for "Grumpy". She looked bashful for "Bashful" and made kissing sounds. The following tape illustrates that lesson. Kim was happy, pleased with the sessions and quite responsive within the limited sounds requested of her. These good days proceeded with little changes in her speech output. We put together an animal farm and Kim laughed when the speech therapist made animal sounds. She refused to enlarge her vocal repetoire however. This good "feeling" session was followed by a session that was difficult for Kim. She had had an unhappy family counselling session and cried throughout the speech session which was ended early. The site of the sessions changed from the speech pathologist's office to the child's room - a more intimate setting. She was told the purpose of our sessions and we continued with our paper farm. She laughed on hearing her sobbing on the tape, before Kim produced the sound "e" for a mouse and varied its loudness level and enjoyed hearing herself. She also produced "e" for the sound a chick makes. She refused to say peep for a chick's sound. In the following days we played with the farm and Kim easily produced "e". She enjoyed watching the needle on the tape recorder jump as she said "e" loudly, as can be heard in this tape segment. She appeared startled but pleased with her newly used voice. Then we began to try to vary the length of this vowel. She would only vary its loudness level. The breakthrough came on September 10. In fun Kim imitated "fff" for an angry cat, "e" for a bird,

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a kiss for the dwarf's kissing, a silent yawn and laughter for Happy as is heard in this taped lesson. Upon completion of the paper farm she was told she could keep the pieces if she imitated the following sounds. We worked progressively until she produced her first word through the method known as successive approximation wherein we gradually approached m target. As this was spontaneous and simply "played by ear" word choice was not as crucial as saying words. As you will hear, the child's pitch level was high, and her voice weak and barely audible. As new vowel combinations were produced she often said only part of the combination but with insistance she produced what was requested of her. As she realized she said words and the speech therapists name she appeared to almost cry out the name. Each repitition of"Debby" was more easily done. Following that word utterance she said "Mary Ellen" O.T." "Play" in one word answers to questions later on. The tape now shows her saying her first word.

In the following session Kim began by counting, naming colors, relating people's names and answering yes/no. After the above momentous session speech flowed easily as can be observed in this tape.

The speech therapist then began to act as a supportative bridge to help Kim to speak with other children, and male therapists. As she spoke more her voice became less whiney, tearful and timid. It still retained a sing song whine but was of acceptable loudness, with good grammatical structure. She substituted a "d" for the voiced "th" such as dat for that. An error not requiring any work especially at this time. Kim's speech sessions became time for play and talk. She stated how hard it had been for her at times not to talk, especially when she needed help or wanted to go to the

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bathroom. She said she was relieved and happy to talk. At times in the Pediatric Ward she continued to withold speech but this reduced. She was always pliable in the speech sessions and as you can now hear we talked quite freely.* She was dismissed from speech therapy when she was discharged from the hospital. Thank you and I regret not being here to deliver this talk personally.

Summary of the Therapeutic Sessions - Fredda Zuckermann

My individual play sessions were initiated a few days after admission. Kim was quite regressed and silly. We played catch, peek-a-boo, hide-and-go-seek. Kim brought some of her stuffed animals to the sessions. In these sessions she would often indicate interest in a game and then refuse to play once everything was organized. Other days she would imitate a dog and crawl on the floor, and like it. We listened to her giggles in the tape recorder, we listened to music and we tried to play with clay, which she clearly disliked. At times she displayed resistance to coming to the sessions; other times she struggled to stay beyond the allotted time.

I talked to her about the unit, trying to explore her adjustment. She indicated that she was afraid that people did not like her.

After the first eight sessions, I felt that I would try to develop the relationship further, by imitating Kim's behavior, posture, movements, etc. We played with blocks, and the stuffed animals she had brought with her. At her initiation we began to work on the drawing of a whale which later became quite significant. Individual treatment was interrupted

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for two weeks as part of the general play for all ancillary services to be discontinued. One week prior, parent visits were discontinued hoping this would foster Kim's relationships on the unit. The parents had agreed to this plan with great reluctance. Mother and father attended parent group meetings indicating how guilt ridden they were about the treatment plan. Father was obsessed about work and asked about when Kim would be coming home. They both needed a great deal of encouragement to attend the group and to interact with other members. Mother only responsive when directly spoken to, She felt hopeless that Kim would get any better.

When Kim's treatment plan was again changed, family therapy, individual play therapy and speech therapy were implemented. Her behavior on the unit shifted. Her involvement increased during the daytime while in the evenings she was depressed and weepy.

In the first session following the interruption Kim was depressed. She arranged the animals on the chair, as before. She indicated interest in coloring the whale, but she did not do so. During puppet play she responded to my zadness about not seeing her for such a long time. In the next session we worked on the whale and my following her lead continued.

Family meetings started and Kim saw her parents for the first time in three weeks. We had arranged it so that family contact would be permitted only in these meetings. We hoped that Kim would feel the need to communicate with them. In the first meetings, Kim sat on mothers lap. In the second session she sat on father's lap and also played with the animals in my office. As we explored the parents relationship with the

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kids at home, Kim made constant noises with a squeaking rubber cat. Father talked about how much he enjoys having Kim sit on his lap. The more he talked about the kids and his feelings of helplessness about his relationship with them, the more anxious Kim became.

In the next session when the discussions focused on Kim and her relationship with the kids at home, her anxiety mounted,, and she urinated. The parents had reported that Kim told the kids that she was a "queen"; the older sister infantilized Kim a great deal. The next session Kim hid in the cartons that were in my office. She occasionally poked her head out as the parents explored how they express anger at the children. Kim giggled when father talked about how the children either imitate him or ignore him. Pant wetting episodes followed this session.

In our concurrent individual play sessions, Kim made some significant changes in her whale drawing. The whale was colorful and all spaces within the whale itself had been carefully colored. In the individual session that followed explorations of kids and parents relationships Kim, for the first time, did not need to have the animals neatly arranged on the chair. Furthermore, to the whale drawing, she added sharp teeth and tiny fish around the mouth. Nonverbally, she indicated that I should put these additions to my drawing as well.

In the family session that followed father's remorse about his role, Kim's behavior was less infantile. She later in this session played catch with the psychiatrist and they got into control struggles; she then played with the animals in my office. In the next few timely sessions mother was depressed. She talked about her frustration.

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Father paid little attention to her feelings and he focused his attention on Kim . When her parents left, Kim cried. In the next session, the psychiatrist confronted Kim with anger about her behavior. She cried. Mother reacted by stating she wanted reassurance from Kim because mother had shared her frustration about Kim's lack of progress. Father was quite anxious and he tried to be overprotective of Kim. Kim cried following the session. Kim had now begun to make noises and sounds in the milieu. In the following family session mother told Kim that she was pregnant. Kim responded by smiling (I suspect Kim may have already known this since earlier that week she had begun to draw baby fish on the whale drawing). Father became depressed. He talked about how tired he had been feeling, stating he had concerns about his medications. In this session he relayed a story about a close friend who had shot himself in the head due to family pressures and work demands. I supported fathers overwhelmed feelings and I tried to explore ways he might manage better. In Kim's following individual session, she made noises in response to a candyland game. In the next family session Kim appeared calm and she interacted less with her parents. Mother was angry and talked about her unmet needs in the marriage; father talked about his fatigue and anxieties about family life and work.

These issues were further explored in the additional sessions. A breakthrough occurred around this time; Kim had begun to verbalize. She talked with a few counselors and she seemed to be exceptionally around men. Her parents were quite pleased with this change although in the family session Kim did not speak. Kim spoke to me in our next individual session.

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We walked outside and she picked lowers and talked about how scary it was to be talking. Other sessions were spent playing with a doll house. She talked about Frankenstein, a monster who came into the house at night and captured various family members. He was a magical mostcr who also returned the members to the house. The family consisted of one baby girl, an older girl and a mother and father. It's significant to note Kim's family did move this month and Kim had not yet seen her new surroundings. Doll play discontinued and the next few sessions focussed on getting Kim ready to attend school.

While still an inpatient, Kim began attending a public school. She had some ambivalence about this; however, I accompanied her on the first several days as I attempted to provide support and reassurance. I also equipped her with one of the oldpuppets we had often played with. This served as a transitional object. Her classmates talked to her and tried to help her get aquainted. Kim was frightened and shy and did not talk, remaining detached. She was fearful about peer acceptance. She often stood in the corner waiting for someone to instruct her. She needed a great deal of reassurance from the teacher. Kim had good, but limited verbal interaction with the teacher. This was a major breakthrough, since Kim had never before spoken to a teacher. Kim's written work was excellent and her art work was beautifully illustrated.

In the hospital Kim's stubborn, controlling struggles continued. There was also an increase in anxiety about peer acceptance. Kim's verbal behavior did continue. She was discharged from the hospital after a total stay of 90

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days. It was also agreed that at this time her school adjustment was adequate; she had spoken to the teacher and to one other child. Outpatient treatment was recommended for Kim and her parents. Thorazine, 25 mgr. three times a day, was discontinued after a month, following the discharge.

Theoretical Considerations

Besides Browne et al's (3) studies and interpretations that have been cited above, Mahler(7) making a reference to a subphase of separation-individuation in a toddler coins the phrase "period of rapprochment" and says:

> ...As the toddler's awareness of separateness grows - an awareness stimulated by his maturationally acquired ability physically to move away from his mother and by his cognitive growth -, he seems to experience and increased need and wish for his mother to share with him every new acquisition of skill and experience. These are the reasons (Mahler) call the subphase of separation-individuation 'THE PERIOD OF RAPPROACHMENT'.
>
> The junior toddler gradually realized that his love objects are separate individuals with their own individual interests. He must gradually and painfully give up his delusion of his own grandeur and participation in the still delusionally believed - in omnipotence of mother and father. Dramatic fights may ensue with mother, and temper tantrums might be in order of the day...
>
> ...From 18 months on, toddlers are quite eager to exercise their rapidly

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growing autonomy. Increasingly, they choose not to be reminded of the times when they could not manage on their own. On the other hand, the desire to be separate, grand, and omnipotent often conflicted with the desire to have the mother magically fulfill all one's wishes - without the need to recognize that help was actually coming from the outside. Thus, in a majority of cases, prevalent mood swung to that of general dissatisfaction and insatiability, and there developed a proneness to rapid swings of mood and to temper tantrums.

Thus, the period of rapproachment is characterized by a sometimes rapid alteration of the desire to reject mother, on the one hand, and to cling to her with coercive, determined tenacity in words and acts, on the other

Should we apply these psychoanalytic considerations to Kim's case, we would say Kim's problems were at the separation-individuation period: not being able to graduate totally from the symbiotic phase, however vacillating back and forth, monitored by ego's experiences with anxiety levels.

Blau (2) reiterating Hebb's neuro-physiological theory of "behavior and brain function and structure", that"stimuli activate clusters and chains of neuronic cells and repitition strengthens intercellular bonds", tries to reconcile physiological and behavioral patterns of personality in the following phrases

...Recent research shows that ongoing balanced mental functioning

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depends considerably on outside stimuli beyond any stability from inner neurological structure. Isolation and sensory deprivation experiments (Lilly, 1956) show that ego function is labile and throws out of balance when support of other stimuli is withdrawn. Screened from sensory stimulation, the ego fragments grossly to schizophrenic-like behavior in a few hours, and when brought back to normal stimuli, it recovers promptly, indicating that a reciprocal feedback system between ego and environment seems constantly necessary. A similar functional process seems to occur nightly when we go to sleep and are cut off from outside stimuli, for in the dream we have a transcient, benign psychotic episode. ...My point is that the functioning and the structure of the brain and ego is neither purely organic and structural nor simply psychological and affected by outside influences. The total personality product involves psyche and soma, and defects in either or both make for faulty ego functioning. Reciprocal matters of both inner neurological organization and the abstract which we call ego is the functioning or physiological and psychological counterpart of a particular disposition of cerebral neuronic pathways...

Personality is molded in a stimulating environment, and experience is imprinted structurally in the brain. The neurological and psychological are interwoven, and it is only an expediant artifact to study one separate from the other...

Therefore, if we can apply these ideas to Kim, we could state that Kim's ego had regressed - temporarily - to schizophrenic-like behavior that could

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be considered transient childhood schizophrenia, due to the fact that she had not been sufficiently exposed to external stimuli.

Mowrer(8), attempting to combine Freud's Pleasure Principle and cathexis with Learning Theory, says:

> Starting with Freud, we had the idea that, when a stimulus is associated with a pleasurable state it takes on "positive cathexis", and when associated with a painful state it takes on "anti-cathexis". Therefore, if Freud had merely gone a step further and had a certain response-produced stimuli giving rise to positive and others to negative "cathexis", he would have anticipated present learning theory perfectly.

Thus according to Mowrer, Kim may have "anti-cathected" whatever she had fearfully absorbed from her parents: insecurities, hidden-unexpressed ambiguities, inconsistancies, anger and so on; responding to painful external stimuli in mutic style that had become a learned behavior, like habit formation. In other words, it was a "passive avoidance learning", according to the "theory of punishment" that interprets the fear the child felt as conditioned to stimuli, either external or response-produced. The organism has made an adjustment to eliminate painful stimuli so as to most effectively reduce the attendant fear.

Eysenck (4) would also interpret Kim's mutism as a learned habit under the category of hysterical aphasia. Remarking that hysterics should develop

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reactive and conditioned inhibition very quickly, he offered the following observations:

> ...according to behaviorists, hysterical aphasia may be regarded as a simple learned habit. To eliminate the aphonia would require the building up of a 'negative habit'. Hull, has shown however that repitition alone does not lead to the establishment of a habit either positive or negative, but merely provides the opportunity for learning if a suitable reinforcement is present. In their experiments, they used the 'rest' and 'reduction of the length' of the session as reinforcement agents.

Eysenck also postulated that stimulant drugs decrease cortical inhibition, increase cortical excitation, and thereby produce "introverted behavior patterns"

As we used Thorazine, a tranquilizer, in Kim's case (theoretically expecting a reverse physiological response to that described above) we might have a) increased cortical inhibition b) decreased cortical excitation and thereby c) promoted an extravertic behavior pattern.
This also links the behavioristic theory with that of the Pavlovian.

Wells (10), referring to Pavlov's chronic schizophrenic case, who had started to function after'twenty years sleep', states:

> Speech is a voluntary action. The central organs of voluntary motions are certain masses of cells in the cortical hemispheres. Since the patient could see, hear, and understand what was going on,

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the other specified cells of the cortex were unimpaired. As in hypnosis, the "ISOLATED INHIBITION" of the motor area of the cerebral hemispheres was the matter. It is functional, physiological, and based on the concept of protective inhibition - like sleep and the phases and degrees of hypnosis and partial sleep. Various forms of irradiating or concentrated protective inhibition occur in the cells of the hemispheres: the most reactive cells in the human organism, when, for example, they are subjected to emotionally strong stimuli exceeding the bounds of endurance; or when there is a too sharp clash of excitatory and inhibitory stimuli - to act and not to act in a certain way. In such instances, the cells may be protected from organic damage by inhibition, a block to excitation. This inhibition may eventually of itself lead, through the rest of the cells, to restoration of normal functioning, a balance of excitation and inhibition.

Therefore, Kim's mutism could have been a "protective inhibition", in a physiological sense not too different than it's psychological equivalence.

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Astrup (1), resynthesizing very brilliantly the Pavlovian school of thought, gives very convincing evidence of interrelations between experimentally induced diseases in animals and corresponding behavior. Here are some selective experiments:

Chernigovski demonstrated that in animals who had suffered from cholecystitis, overstrain of the nervous processes led to relapses, which in many cases also were complicated with acute pancreatitis. Bushujev observed catatonic stages in dogs with tuberculosis disease which re-appeared with experimental overstrain of the nervous processes after the tuberculosis disease had been cured.

Kanin showed that partial removal of the cerebral cortex in rats considerably delayed the structural and functional restoration of the liver after toxic hepatitis.

Framishtein and Lifshits found that myocardial lesions in dogs gave essentially the same functional changes in animals with an intact cerebral cortex as in those in whom the cerebral cortex had been removed. After recovery, electrically produced convulsions brought about reappearance of cardiac symptoms in the decorticated dogs, but not in the others.

..Balitsky removed one kidney in rabbits and investigated the urinary secretion of the remaining kidney, in intact animals and after unilateral e extirpation of the cerebral cortex. With an intact cerebral cortex, the removal of one kidney did not change the specific gravity of the urine essentially. Hyposthenuria resulted when nephrectomy was carried out at the same side as the cerebral cortex removed , while operation on the

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opposite side led to compensatory renal hypertrophy.

Kan Kan demonstrated that the higher the animal is in the evolutionary scale, the greater is the importance of the compensating functions of the cerebral cortex. Thus, after unilateral decortication in frogs, there are no or only short-lasting changes in the functions of internal organs, while in birds, similar operations led to marked and stable inhibition of cardia activity, respiration and gastric motility.

...All the experiments mentioned above illustrate the physiological basis of the clinical concept of 'locus resistentiae'. In these cases, there are compensated, but weak spots, which are related to certain reflex mechanisms. Every event which produces general neurotic conditions causes a more severe course of illness and decreased resistance. In particular, relapses of diseases of internal organs follow disturbances of the cortical regulation.

Thus, we can assume that, in Kim's case, there was a disturbance in cortical regulation, in certain brain cells, very specifically, perhaps around sensory-motor pathways and/or speech center.'

Astrup, also studying the speech process under the light of conditional reflex theory, seeing it as a psycho-physiological interaction between the child and his immediate environment, offers the following interpretations:

In children from one to two years, the stages in the development of conditional relexes to each complex stimuli with word components can be seen. First, the temporal connections are predominantly tactile,

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kinesthetic, then visual, and finally, auditory. In the auditory component, words are the last to be differentiated, and are gradually substituted for the concrete stimuli from the external world.

The development of adequate motor reactions to words in this period represents a 'formation of conditional reflexes' to concrete speech sound. ..The ability to elaborate conditional reflexes to exteroceptive stimuli signaling an unconditional stimulus is common both to man and animals. These temporal connections are called CONDITIONAL REFLEXES in the 'first signaling system'. However, from a neurophysiological point of view, man is primarily distinguished from animals by his ability to use words and concepts as signals of the reactions in the first signaling system, so that in Pavlovian physiology speech is defined as the reactions in the "second signaling system".

The Second Signaling System is far more complicated than the First Signaling System, and shows various levels of complexity starting with elementary speech responses, passing on to concrete concepts, and reaching the highest level in abstract thought. It includes not only the intellectual functions, but also the more complex types of emotional and voluntary functions.

The highest psychic activity can be investigated according to the same principles as the more elementary cortical functions of the first signaling system. This concept also makes it possible to bridge the traditional dualistic attitude that the psyche and the soma are basically different phenomena, because the conditional reflex is a physiological process which is experienced as a psychic event.

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Finally, turning to Piaget and his school for some interpretations, we could utilize the following:

> Pre-psychotic children seem to remain in a sort of intellectual and emotional adualism, They develop numerous avoidance- and withdrawal mechanisms in order to escape from encounters with other people and with the facts of"physical reality". They have a tendency to assimilate in an egocentric manner the information received, and to alter it according to needs and fears which dominate them...The disturbing effects that the distortion of interpersonal relations has on the operativity of the "pre-psychotic" child show us how intimately the formation of cognitive structures is linked to the adaptive function of thought.
>
> Here again, the mutually sustaining and complementary roles of psychopathology, psychoanalysis, and the study of cognitive development became increasingly clear. The emotional and the intellectual aspects of development cannot be dissociated, and a study of the dynamics of cognitive function finds it necessary counterpart in the study of the dynamics of emotional development.

Ryan (9) interprets Piaget's view of child's language development and socialization as follows:

> It is a sociological commonplace that language is an important instrument of socializtion.
>
> PIAGET is the only psychologist so far to have shown a sustained interest

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in the nonverbal prerequisites for the beginning of language. PIAGET (1946) describes language development within the general framework of the transition from sensory-motor to representational modes of thought. (his interest is not primarily in the form of structure of early speech, nor in the details of interaction with adults who speak to the child)

Piaget does not regard language as 'sui generis', something that requires special equipment to explain it's appearance, independently of other cognitive development. Nor does Piaget regard language as something to be studied as the object of the child's knowledge, in the way that current psychoanalytic theory does. Rather, apart from the very early stages, he sees it a means of knowing and thinking.

Piaget sees language as simply one facet of cognitive development, providing an economical means of representing reality.

There are two important features of Piaget's account. First, Piaget's notion of the representative or symbolic function, and the associated distinction he draws between the 'true' and objective use of words, and their earlier and changing and subjective use...

In the broader sense, 'representation' is identical with thought, i.e. all intelligence which is based on a system of concepts or mental schemes and not merely on perceptions and actions.

Further, representation 'goes beyond the present, extending the field of adaptation both in space and time'. Representative thought in this broader sense develops concurrently in different areas, in the child's conception of objects, space, time and causality.

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The second important feature of Piaget's account in his tracing of the origins of the language development and representative thought in general in previous non-verbal development. The non-verbal roots of representation are t to be found in imitation and play.

According to Piaget, imitation develops so that by the final stage of sensory-motor period the child is able to reproduce, without prior practice, unfamiliar models and actions in their absence. Such ability must involve some system of internal representation on which the deferred imitation is based, and Piaget suggests mental images for this role. Thus, "imitation is no longer dependent on the actual function, and the child becomes capable of imitating internally a series of models in the form of images or suggestions of actions"

Therefore,if we endeavour to interpret Kim's elective mutism,according to PIAGET, we cannot find a direct reference to it hor he basically is interested in explaining the ongoing processes of speech development;yet, we could say that Kim's conflict was in her pre-verbal ,imitation and play episode,prior to final stage of sensory-motor development that induced speech. In other words, the internalization of mental images of the words were 'temporarily'blurred ,as if they were not achieved. Or, if speech was a menas of 'knowing and thinking', she 'temporarily' did act as if she 'did not know', and 'did not think',cancelling the representation of some mental images, as a verbal sign.

Summary

SUMMARY: Kim, an eight year old child, who had never spoken to anyone other than her parents in her lifetime, was admitted to a pediatric-psychiatric unit of a local general hospital for both diagnostic and therapeutic purposes.

The observation and evaluation revealed that her sensory-motor pathways for speech, cognitive functioning in understanding the meanings of words and in the phonetic expression of words were all within normal limits. Gross and fine motor functions were also intact. Yet, she had 'electively chosen' not to talk.

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Family dynamics revealed a mother who identified herself closely with the child, and who also had quite hostile-dependent relations with the husband. Father showed passive-aggressive personality characteristics with borderline features. Kim impressed us as an anally aggressive child, with tremendous oral aggressive fantasies, afraid of expressing her angry feelings about parental interactions that had the quality of silent anger and inconsistancy. Therefore, "not to talk" was a protective device against oral aggression, as well as a means of rebelliousness and controlling device against parental practices.

The therapy consisted of a combination of milieu: individual, group, play and speech therapies; O.T.; activities, primarily utilizing behavior modification techniques; and combined family therapy. Phenothiazines were final additives. The result has been a most rewarding one, for thirteen months after discharge, the child successfully continues to speak and perform both at home and in school, in spite of the fact that she now has a newborn sibling and the family has moved to a new environment.

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R E F E R E N C E S:

1. Astrup, Christian "Pavlovian Psychiatry - A New Synthesis", Charles C. Thomas, Publ., Springfield, Ill. 1960

2. Blau, Abram "Childhood Schizophrenia", Journal of American Academy of Child Psychiatry 1:225-235, 1962

3. Browne, Evelyn et all. "Diagnosis and Treatment of Elective Mutism in Children", J. of American Academy of Child Psychiatry, 2:605-617, 1963

4. Eysenck, H.J. "Behavior Therapy and Neuroses", Pergamon Press, London, 1960

5. Inhelder, Barbel et all. "Piaget and His School - A Reader in Developmental Psychology", Springer Verlag, N.Y. 1976

6. Lewis, M.M. "How Children Learn to Speak?", Basic Books, Inc. N.Y. 1959

7. Mahler, Margaret S. "Symbiosis and Individuation", The Psychological Study of the Child, 29:89-106, 1976

8. Mowrer, O. Robert "Learning Theory and Behavior", John Wiley and Sons, Inc. New York, 1960

9. Richards, Martin P.M.(Ed.)- Ryan, Joanna "The Interaction of a Child Into a Social World", Cambridge University Press, New York, 1974

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REFERENCES:

10.Wells, Henry K. "Ivan P. Pavlov", International Publications, New York, 1956